WELLFLEET INSURANCE COMPANY
5814 Reed Road Fort Wayne, Indiana 46835
Administered by:
Wellfleet Group, LLC
PO Box 15369, Springfield, MA 01115-5369

ENROLLMENT/CHANGE REQUEST FORM FOR GROUP INSURANCE

ACTION REQUESTED:

☐ New Enrollment

BENEFIT INFORMATION	
GROUP ACCIDENT ☐	**CRITICAL ILLNESS ☐**
Plan elected: ☐ **Low** ☐ **High**	**Plan elected**: ☐ **$10,000** ☐ **$20,000**
Coverage Tier – Select One Option ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee & Family	**Coverage Tier – Select One Option** ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee & Family

PERSONS TO BE COVERED

Full Name (Please PRINT):	**Relationship**	**Gender**	**Date of Birth**	**Social Security #**	**U. S. Citizen**
	Employee (Self)				☐ Yes ☐ No
	Spouse				☐ Yes ☐ No
	Child				☐ Yes ☐ No
	Child				☐ Yes ☐ No
	Child				☐ Yes ☐ No

EMPLOYEE INFORMATION

Street Address:			City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:		Email Address:	

EMPLOYMENT INFORMATION

Employer Name:	Employee Number (if applicable):	Date of Hire:		
Employer's Street Address:		City:	State:	Zip:
Occupation:		Scheduled # of Work Hours/wk:	Are you Actively at Work? ☐ Yes ☐ No	

BENEFICIARY INFORMATION

EMPLOYEE	SPOUSE (if covered)
Primary Beneficiary (name and relationship):	Primary Beneficiary (name and relationship):
Secondary Beneficiary (name and relationship):	Secondary Beneficiary (name and relationship):

TO BE COMPLETED WHEN ENROLLING FOR CRITICAL ILLNESS INSURANCE

	Employee		Spouse	
	Yes	**No**	**Yes**	**No**
1. Has any person to be insured, used tobacco products (cigars, cigarettes, pipe, snuff, dip, chew, or any other nicotine delivery system, patch, etc.) during the past 12 months preceding the date on this form?	☐	☐	☐	☐

REPLACEMENT COVERAGE

GROUP ACCIDENT ☐ **CRITICAL ILLNESS ☐**

Will any insurance with this or any other company be replaced or changed if the coverage applied for is issued? If yes, provide company name, address, policy number and complete required replacement form, if applicable in your state.	☐ Yes ☐ No
Insurance Company Name and Address:	Policy Number

AUTHORIZATION FOR PAYROLL DEDUCTION

Employee hereby authorizes Central States Indemnity to deduct from my salary to pay the required premium for my coverage.

Signature of Employee:_____ Date: _____

EMPLOYEE SIGNATURE AND AUTHORIZATION

I understand that my coverage may be subject to limitations, exclusions and terminations as described in the enrollment materials or employee certificate(s) that have been provided to me by my employer. I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available to me at my request. I authorize my [employer] to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

In signing below, I: (a) represent that the statements and answers given in this Evidence of Insurability form, are true, complete and correctly recorded to the best of my knowledge and belief; (b) understand that the insurance applied for is not effective until the application is approved by Wellfleet Insurance Company [(c) authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, or MIB Group, Inc. having information on me regarding my mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to Wellfleet Insurance Company, its reinsurers, or its legal representative any and all such information to use for underwriting insurance or other purposes such as the detection of fraud or other related business purposes. I understand any claim for benefit may require a separate authorization.

To facilitate rapid submission of such information, I authorize all said resources, to give such records or knowledge to any agency employed by the Company to collect and transmit such information.

This authorization shall be valid for twenty-four (24) months from the date signed below. This authorization may be revoked upon written request to Wellfleet Insurance Company and will not remain valid beyond the date the revocation is received by Wellfleet Insurance Company. I understand that the revocation may be a basis for denying my insurance application, and that it does not alter Wellfleet Insurance Company's right to use this evidence of insurability for purposes of determining misrepresentation once coverage has been issued.

I have read and understand the above statements and agreements.

Dated at:_____ on:_____ 20 _____

City, State & Zip Month & Day

Electronic Signature of Employee:_____ ☐ I agree

By clicking the box marked "I agree," I acknowledge that I am signing this document electronically. I understand that this electronic signature shall be enforceable under the applicable state or federal law and is equivalent to a manual signature.

AGENT'S STATEMENT

I represent: 1) That any information recorded by me is true and correct to the best of my knowledge and belief. 2) This (does) (does not) replace other insurance.

Dated:_____ on_____ 20 _____

Agent Name (Print) Agent Signature Agent No.

CONSENT TO ELECTRONIC DELIVERY

Written communications may be delivered electronically. I understand that I will need to have a computer capable of accessing the Internet, a valid email address to access and retain electronic records and software capable to view a PDF.

I may request a paper version of the electronically furnished documents at any time by contacting Wellfleet Insurance Company.

Your consent to Electronic Delivery will remain in effect and will apply to all future renewals, continuations, replacements and changes to any Policy(ies) or Billing Account(s) unless:

- You withdraw your consent in accordance with these terms and conditions; or
- We terminate the Program, your enrollment in the Program or the enrollment of a Policy or Billing Account.

By signing below, I agree and consent to the terms and conditions set forth in this Consent to Electronic Delivery section, including, but not limited to, the use of electronic signatures. I agree to receive all mailings and communications electronically at the email address provided below.

Right to Withdraw Consent. You have the right to withdraw your consent to receive electronic communications at any time by contacting us:

Wellfleet Insurance Company
c/o Wellfleet Group, LLC
PO Box 15769
Springfield, MA 01115-5769
855-664-5838

I have read and understand the above statements. on:_____
Date

Signature:_____ Email Address: _____

Fraud Warning

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in

prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

All other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.